CHAPTER 4

Physician and other health professional services

RECOMMENDATION

4 The Congress should update payments for physician fee schedule services in 2012 by 1 percent.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

CHAPTER 4

Physician and other health professional services

Chapter summary

Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In 2009, fee-for-service (FFS) Medicare spent about $64 billion on physician and other health professional services, accounting for 13 percent of total Medicare spending and 20 percent of Medicare's FFS spending. Among the 1 million clinicians in Medicare's registry, about half are physicians who actively bill Medicare. The remainder includes other health professionals, such as nurse practitioners, chiropractors, and physical therapists. These health professionals may bill Medicare independently (accounting for 10 percent of physician fee-schedule spending) or provide services under physician supervision. Almost all FFS Medicare beneficiaries (98 percent) received at least one physician service in 2009.

Two key issues serve as context for considering the adequacy of payments to physicians. The first is beneficiary access to primary care. While our analysis finds that access to physician and other health professional services is good nationally, a small share of the Medicare population continues to report problems finding a new primary care physician. This challenge raises serious concerns not only for the beneficiaries who are personally affected but also—on a larger scale—for the functioning of our health care delivery system. The Commission has recommended enhancements to primary care, such

In this chapter

as increasing Medicare payments for primary care services provided by primary care practitioners. Adoption of this policy by the Congress marks an important step toward ensuring beneficiaries' access to primary care, but more levers should be explored, including taking better advantage of the care management skills that advanced practice nurses and other health professionals can provide and exploring other payment approaches to promote primary care.

The second issue centers on the government's budgetary mechanism to address growth in Medicare spending for physician and other health professional services—called the sustainable growth rate (SGR) system. In previous reports, the Commission reiterated several widely held criticisms and flaws of the SGR system, while recognizing that its existence may have constrained updates in recent years.

A main flaw of the SGR is its blunt approach: In setting across-the-board updates to Medicare's physician fee schedule, the system neither rewards individual providers who restrain unnecessary volume growth nor penalizes those who contribute most to volume increases. Also, the SGR does little to counter the volume incentives that are inherent in FFS payments. In fact, volume growth is one of the major factors that has caused cumulative spending to exceed the SGR's cumulative target.

Current law—under the SGR system—calls for Medicare to cut fees for physician and other health professional services by more than 30 percent over the next several years. There is general consensus that such dramatic fee cuts would be detrimental to beneficiary access to care, and legislative overrides of the SGR have successfully averted payment cuts in recent years. However, these overrides are merely temporary, and their short-term nature has been problematic for providers and burdens CMS's resources. In addition, several of the earlier overrides contributed to the amount of dollars that must be recouped through cuts.

Although it seems counterintuitive that longer term changes—with more realistic future updates—have not been passed into law, such proposals are quite costly (from a budgetary scoring perspective) because they eliminate some or all of the scheduled fee cuts. But, a potentially more pressing Medicare cost to consider is the mounting frustration of physicians, other health professionals, and their patients if substantial Medicare fee cuts continue to loom large in future years. The Commission plans to continue to work on SGR payment policies and consider various approaches for updating Medicare's physician fee schedule.

Notwithstanding these SGR issues, our analysis of Medicare's payment adequacy for fee-schedule services provided by physicians and other health professionals

finds that most indicators are positive and stable, suggesting that, at current payment levels, most beneficiaries can obtain care on a timely basis.

Beneficiaries' access to care—Overall, beneficiary access to physician services is good and better than that reported by privately insured patients age 50 to 64. For 2010, 75 percent of beneficiaries reported that they had no problem scheduling timely routine-care physician appointments; percentages were even better for illness/injury appointments. Among beneficiaries looking for a new physician, most could find one without major problems; however, finding a primary care physician was more difficult than finding a specialist. As in past surveys, racial and ethnic minorities in both the Medicare and the privately insured populations were more likely to experience access problems.

Other indicators of access include the supply of providers serving Medicare beneficiaries and changes over time in the volume of services provided.

- ***Supply of providers—***The 2008 National Ambulatory Medical Care Survey found that among physicians with at least 10 percent of their practice revenue coming from Medicare, 90 percent accepted at least some new Medicare patients. By specialty, 83 percent of primary care physicians and 95 percent of non–primary care physicians accepted at least some new Medicare patients.
- ***Volume of services—***Service volume per beneficiary continued to grow in 2009. Overall volume (including both service units and intensity) grew 3.3 percent per beneficiary. This rate was slightly lower than the 2008 rate of 3.6 percent. Growth rates varied among broad categories of services, but all were positive.

Quality of care—Most claims-based indicators for ambulatory quality that we examined for the elderly improved slightly or were stable from 2007 to 2009.

Medicare payments and providers' costs—We cannot examine financial performance directly because physicians and other health professionals are not required to report their costs to Medicare. Instead, we analyze indirect measures:

- Medicare's payment for physician fee-schedule services in 2009 averaged 80 percent of private insurer payments for preferred provider organizations, a figure unchanged from the preceding year.
- Depending on the specialty, some specialists received compensation in 2007 that averaged twice the compensation for primary care physicians.
- Regarding inflation in providers' costs, CMS's forecasts of the Medicare Economic Index for 2012 range from 1.0 percent (most recent) to 0.7 percent. ■

Background

Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities, other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Among the 1 million clinicians in Medicare's registry, approximately half are physicians who actively bill Medicare. The remainder includes other health professionals such as nurse practitioners, chiropractors, and physical therapists. These health professionals may bill Medicare independently (accounting for 10 percent of physician fee-schedule spending) or provide services under physician supervision.

Billed to Medicare Part B, fee-for-service (FFS) payments for physician and other health professional services totaled $64 billion in 2009, accounting for about 13 percent of Medicare's overall spending and 20 percent of Medicare's FFS spending (Boards of Trustees 2010). In the decade 2000 through 2009, Medicare spending per beneficiary on physician fee-schedule services grew 62 percent. Almost all FFS Medicare beneficiaries (98 percent) received at least one physician service in 2009.

In the FFS program, Medicare pays for physician services according to a fee schedule that lists services and their associated payment rates. The fee schedule assigns each service a set of three relative weights (physician work, practice expense, and professional liability insurance) intended to reflect the typical resources needed to provide the service. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payment amounts. In general, Medicare updates payments for physician services by increasing or decreasing the conversion factor. For further information, see the Commission's *Payment basics: Physician services payment system*.[1]

By law, the update of the physician fee schedule conversion factor is determined by a formula—the sustainable growth rate (SGR)—set forth in the Balanced Budget Act of 1997. It ties payment updates to four factors: changes in input costs, changes in Medicare FFS enrollment, changes in the volume of physician services relative to growth in the national economy, and changes in law and regulation. Although the SGR formula has yielded negative updates in recent years, the Congress has overridden the formula and taken a series of legislative actions to prevent payment reductions since 2003. Payments for physician services are slated to decline at least 25 percent in 2012 with another cut in 2013, as required by the SGR system.

The mounting cost of looming cuts in Medicare

The Commission asserts that Medicare is facing an additional cost related to the current SGR—namely, mounting frustration in the provider community stemming from the uncertainty of future Medicare payments, with looming payment cuts in the balance. Often referred to as "temporary fixes," legislative SGR overrides have accounted for relatively small periods of time. For 2011, the Congress passed a 1-year override; for 2010—two 1-month overrides, two 2-month overrides, and one 6-month override. While these stop-gap measures successfully averted payment cuts, their short-term nature has been problematic.

Physician organizations and news media have cited provider dissatisfaction, stress, and frustration with the insecurity of Medicare's future payments for physician services. Additionally, in 2010, CMS experienced a significant administrative burden when it had to delay claims payments in anticipation of a legislative override. Physician groups reported that this delay, in addition to the payment update debates, caused cash flow problems and uncertainty for some physicians, particularly those in smaller practices.

Another issue with several of the earlier overrides is that they added to the total amount of dollars that must be recouped in accordance with the SGR formula. Thus, these overrides resulted in increasing the deficit between actual cumulative spending and the SGR cumulative target.

Other SGR policy considerations

In previous reports, congressional testimony, and discussions at the Commission's public meetings, the Commissioners have reiterated several widely held criticisms and flaws of the SGR system, while recognizing that its existence may have restrained updates in recent years. A main flaw of the current SGR system is its inability to differentiate by individual provider;

it neither rewards specific physicians who restrain unnecessary volume growth nor penalizes those who contribute most to inappropriate volume increases. Also, the SGR does little to counter the volume incentives that are inherent in FFS payments.

In previous Commission analyses, we examined several proposals to modify the SGR. They include differential expenditure targets by categories of services, reconfiguring the SGR formula through technical changes, SGR exemption policies, and a broader expenditure target. Each has advantages and disadvantages, and we discuss them briefly below. However, because current law requires such deep payment cuts, none of these options alone could realistically offer positive updates to physicians and other health professionals. If some providers earned positive updates under current SGR targets, the negative updates borne by the remaining physicians and health professionals would be far greater than 30 percent over the next several years.

Differential expenditure targets by categories of service

A type-of-service option assigns separate target growth rates for specified categories of services (e.g., primary care, imaging). Under this approach, services in categories that exceeded their target growth rate would receive lower subsequent updates than those that were closer to their targets. This option recognizes that spending growth rates differ widely across service categories and attempts to partially ameliorate the criticism that the current system penalizes or rewards all physicians identically, regardless of the individual's or the specialty's contribution toward meeting or exceeding the aggregate expenditure target. Another advantage to a type-of-service approach is that it creates an opportunity to boost payments for categories of services that may be undervalued or underused. For example, in the case of recent legislative proposals, primary care targets were increased.

One challenge for this approach lies in determining ways to adjust for evolving changes in the optimal mix of services that patients receive. To account for such changes, service-specific targets would have to consider factors such as changes in the population, patterns of illness, medical knowledge, and medical technologies—all of which could be associated with clinically appropriate substitution of services across categories.

Technical changes to reconfigure the formula

The SGR formula could be reconfigured to establish more realistic and stable updates. One such option is to amend or eliminate the cumulative aspect of the formula. Updates could be based on annual targets, rather than cumulative ones, for example. This annual target method was used under the volume performance standard (VPS)—the update system for physician services in place before the SGR. The VPS required excess spending from a single year rather than multiple years to be recouped but limited the amount recouped with a floor. Excess spending (spending above the target) that could not be recouped within the floor limits, in essence, was forgiven. An alternative to totally eliminating the cumulative aspect of the SGR would be to count a portion rather than all of excess spending in the calculation of actual cumulative spending (e.g., 50 cents of every dollar above the target).

A second option is to relax the precision of the spending target by creating an allowance "corridor" when comparing actual expenditures with target spending. This modification would not require an exact match of actual spending and target spending but instead would trigger a negative (or positive) update only when the difference exceeded a specified corridor, such as 2 percentage points, around the calculated target. Spending that exceeded this additional allowance would still need to be recouped but only enough to bring actual spending in line with the boundary of the corridor rather than all the way back to the precise target. As a result, some excess volume would be forgiven.

The main advantages of these technical adjustments are that they could provide more realistic and stable updates while retaining some degree of expenditure control. However, to the extent that these approaches forgive any spending above the SGR target, they will result in higher budgetary costs than the SGR system.

SGR exemption policies

In previous Commission work and in current discussions, the Commission examined SGR alternatives that would allow certain providers to be exempt from the current SGR target. These may include physicians and health professionals who become part of an accountable care organization (ACO) and participate in Medicare's ACO program. Currently being designed by CMS, this program is intended to hold health care providers accountable for the quality, cost, and overall care of a population of FFS Medicare beneficiaries and will include incentives

for improving care quality and efficiency. Another set of providers to consider for exemption from SGR updates might be medical practices that qualify as medical homes—providing full care coordination and other patient services. The Commission has also explored policies that identify providers whose Medicare expenditures are outliers compared to peers in their specialty. In general, these exemption options can provide improved accountability, relative to the current SGR, but would affect varying—and in many cases small—numbers of physicians.

Broader expenditure target

In our 2007 report examining SGR alternatives, the Commission explored the concept of a broad expenditure target encompassing all of FFS Medicare. Broader expenditure targets would allow for more flexibility in setting targets among different settings, provider types, and categories of services. In doing so, expenditure targets would not be borne solely by physicians. However, a broader expenditure target also carries many of the same risks as the current SGR system—namely, being too removed from individual providers to create appropriate incentives for efficiency.

The Commission plans to continue discussing SGR payment policies in its upcoming work and to consider various approaches for updating payments for physician and other health professional services.

Are Medicare payments adequate in 2011?

Our analysis of payments for physician services in FFS Medicare shows that, in the aggregate, current payments are adequate. Our assessment examines several indicators: beneficiary access to physician care, including rates of physicians participating with Medicare and taking assignment, and changes in the volume of services provided, quality of care, and Medicare reimbursement levels compared with those in the private sector. In the most recent years for which we have data, each indicator was positive or stable with respect to payment adequacy. Unlike our payment adequacy assessments of other providers, such as hospitals, we cannot look at financial performance of physicians directly because they are not required to report their costs to Medicare.

Beneficiaries' access to care: Generally good with relatively few problems reported

Physicians are often the most important link between Medicare beneficiaries and the health care delivery system. Our analysis of the 2008 Medicare Current Beneficiary Survey shows that about 85 percent of noninstitutionalized FFS beneficiaries report that a doctor's office or clinic is their usual source of care. Beneficiary access to physicians, therefore, is an important indicator to monitor when assessing Medicare's payment adequacy. Our analysis of access to physician services focused on indicators from several sources, including patient surveys, physician surveys, beneficiary focus groups, physician focus groups, and claims data.

2010 patient survey shows that, overall, access is good, but primary care continues to be a concern

To obtain the most current access measures possible, the Commission sponsors a telephone survey each year of a nationally representative, random sample of two groups of people: Medicare beneficiaries age 65 years or older and privately insured individuals age 50 to 64. The overall sample size is 4,000 in each group (totaling 8,000 completed interviews, including an oversample of minority respondents).[2] By surveying both groups of people—privately insured individuals and Medicare beneficiaries—we can assess the extent to which access problems, such as delays in scheduling an appointment and difficulty finding a new physician, are unique to the Medicare population.[3]

Results from our 2010 survey indicate that most beneficiaries have reliable access to physician services, with most reporting few or no access problems. Most beneficiaries are able to schedule timely medical appointments and find a new physician when needed, but some beneficiaries experience problems, particularly when they are looking for a primary care physician. Medicare beneficiaries reported similar or better access than privately insured individuals age 50 to 64.

On a national level, this survey does not find widespread physician access problems, but certain market areas may be experiencing more access problems than others due to factors unrelated to Medicare—or even private—payment rates, such as relatively rapid population growth. Moreover, although the share of beneficiaries reporting major problems finding a primary care physician is small, this issue is a serious concern not only to the beneficiaries who are personally affected but also—on a larger scale—for the functioning of our health care

delivery system. The Patient Protection and Affordable Care Act of 2010 (PPACA) contains several provisions to enhance access to primary care, including increasing Medicare payments for primary care services provided by primary care practitioners. This policy marks an important step toward ensuring access, but more levers should be explored. Regulatory changes have also resulted in some payment increases for services that primary care providers frequently provide. The Commission will continue examining multiple approaches for improving Medicare's payment policies to promote primary care.

Most beneficiaries report timely appointments

Because most Medicare beneficiaries have one or more doctor appointments in a given year, an important access indicator we examine is beneficiaries' ability to schedule timely appointments. In the 2010 survey, among those seeking an appointment, most beneficiaries (75 percent) and most privately insured individuals (72 percent) reported "never" having to wait longer than they wanted for an appointment for routine care (Table 4-1). Another 17 percent of Medicare beneficiaries and 21 percent of privately insured individuals reported that they "sometimes" had to wait longer than they wanted for a routine appointment. The differences between the Medicare and privately insured populations in their "never" and "sometimes" response rates were statistically significant, suggesting that Medicare beneficiaries were more satisfied with the timeliness of their routine care appointments.

As expected, rates for getting timely illness- and injury-related appointments were better than rates for routine care appointments. Among those needing appointments, Medicare beneficiaries were more likely than privately insured individuals to report "never" having problems getting timely illness or injury appointments (83 percent of Medicare beneficiaries and 80 percent of privately insured individuals); 13 percent of Medicare beneficiaries and 15 percent of privately insured individuals reported "sometimes" having to wait longer than they wanted. These differences are statistically significant, suggesting that Medicare beneficiaries were slightly less likely than privately insured individuals to encounter delays for illness and injury appointments.

Beneficiaries' access to appointments in 2010 varied by race, with minorities reporting access problems more frequently than whites (Table 4-2, p. 78). This racial disparity existed for both the Medicare and the privately insured populations but was wider among privately insured patients. For example, among Medicare beneficiaries who sought an appointment, a 2 percentage point difference existed between white and minority beneficiaries reporting never waiting longer than they wanted for routine care appointments. This difference was 7 percentage points among privately insured whites and minorities. The trend was similar for illness and injury appointments. A wider disparity among the privately insured population may reflect variation in private market insurance designs.

Finding disparities in access between whites and minorities has been documented by a large body of research, notably summarized in the Agency for Healthcare Research and Quality's 2008 *National Healthcare Disparities Report.* Although disparities among the Medicare population are generally smaller than in the non-Medicare population, disparities related to race, ethnicity, and socioeconomic status remain a factor in beneficiary access to care (Agency for Healthcare Research and Quality 2008, Institute of Medicine 2002, Reschovsky and O'Malley 2008, Williams et al. 2004).

In addition to the ease of scheduling appointments, our survey also asks about respondents' ability to find a new physician if they are seeking one. As in previous years, relatively few survey respondents reported that they tried to find a new primary care physician or specialist in the past year. This finding suggests that most respondents were either satisfied with their current physician or did not have a health event that made them search for a new one. Specifically, 7 percent of Medicare beneficiaries and 7 percent of privately insured individuals reported that they looked for a new primary care physician in the preceding year; a larger percentage (13 percent of Medicare beneficiaries and 15 percent of privately insured individuals) reported seeking a new specialist (not shown in table).

Finding a primary care physician appeared to be more difficult for privately insured individuals than for Medicare beneficiaries. Specifically, among the small share of people (7 percent in each insurance group) who looked for a new primary care physician in the past year, 79 percent of Medicare beneficiaries and 69 percent of privately insured individuals reported that they had no problem finding one. This difference is statistically significant.

Among the 7 percent of Medicare beneficiaries who sought a new primary care physician, 20 percent reported a problem, compared with 31 percent for the privately insured. Of the patients reporting a problem, 8 percent of Medicare beneficiaries characterized their problems

TABLE 4–1

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2007–2010

	Medicare (age 65 or older)				Private insurance (age 50–64)			
Survey question	**2007**	**2008**	**2009**	**2010**	**2007**	**2008**	**2009**	**2010**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	75%*	76%*	77%*	75%*	67%*	69%*	71%*	72%*
Sometimes	18*	17*	17*	17*	24*	24*	22*	21*
Usually	3	3*	2*	3*	4	5*	3*	4*
Always	3	2	2	2	3	2	3	3
For illness or injury								
Never	82*	84*	85*	83*	76*	79*	79*	80*
Sometimes	13*	12*	11*	13*	17*	16*	17*	15*
Usually	3	1	2	2	3	2	2	2
Always	2	1*	1	1*	3	2*	2	2*
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new primary care doctor?"								
Yes	9	6	6	7	10	7	8	7
No	91	93	93	93	90	93	92	93
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor / specialist who would treat you? Was it…"								
Primary care physician								
No problem	70*	71	78	79*	82*	72	71	69*
Small problem	12	10	10	8	7	13	8	12
Big problem	17	18	12*	12	10	13	21*	19
Specialist								
No problem	85	88	88	87*	79	83	84	82*
Small problem	6	7	7	6*	11	9	9	11*
Big problem	9	4	5	5	10	7	7	6
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")	10*	8*	7*	8*	12*	12*	11*	12*

Note: Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in 2007, 3,000 in 2008, and 4,000 in 2009 and 2010. Sample sizes for individual questions varied.
*Statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone survey conducted in 2007, 2008, 2009, and 2010.

TABLE 4–2

Medicare beneficiaries have better or similar access to physicians compared with privately insured individuals, but minorities in both groups report problems more frequently, 2010

	Medicare (age 65 or older)			Private insurance (age 50–64)		
Survey question	**All**	**White**	**Minority**	**All**	**White**	**Minority**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	75%*	76%*	74%*	72%*	73%*†	66%*†
Sometimes	17*	17*	17*	21*	20*	23*
Usually	3*	3	3*	4*	4	6*
Always	2	2	3	3	2	4
For illness or injury						
Never	83*	84*†	80*†	80*	81*†	74*†
Sometimes	13*	12	14*	15*	14†	20*†
Usually	2	2	2	2	2	2
Always	1*	1*†	2†	2*	2*	3
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new primary care doctor?"						
Yes	7	7	7	7	7	6
No	93	93	92	93	93	94
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor / specialist who would treat you? Was it…"						
Primary care physician						
No problem	79*	80*	76	69*	69*	67
Small problem	8	7	9	12	11	15
Big problem	12	12	14	19	19	18
Specialist						
No problem	87*	89*†	78†	82*	83*†	73†
Small problem	6*	5*†	11†	11*	11*	14
Big problem	5	5	9	6	5†	13†
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")	8*	8*	9*	12*	12*	12*

Note: Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not presented. Overall sample size for each group (Medicare and privately insured) is 4,000. Sample sizes for individual questions varied.
*Statistically significant difference between the Medicare and privately insured samples at a 95 percent confidence level.
†Statistically significant difference by race within the same insurance category at a 95 percent confidence level.

Source: MedPAC-sponsored telephone surveys, conducted May–September 2010.

as "small," compared with 12 percent of the privately insured; 12 percent of Medicare beneficiaries reported their problem as "big," compared with 19 percent of the privately insured. These comparative rates in 2010 were similar to those found in our 2009 survey.

Because several recent media reports and association publications have misstated the numbers that we present in this annual chapter, we want to emphasize, at the risk of being redundant, that the percentage of beneficiaries and privately insured people reporting problems comes from a subset of those who indicate that they were, in fact, looking for a new physician or tried to schedule an appointment in the last year. Survey respondents who did not look for a new physician or did not try to make a physician appointment were not asked about related problems. Thus, the rates of patients reporting problems refer only to those people to whom the question applies and not to the Medicare or privately insured population at large. Accordingly, among the 7 percent of Medicare beneficiaries reporting that they looked for a new primary care physician in the preceding year, those reporting that they experienced a "big" or a "small" problem correspond to less than 2 percent of the total Medicare population. Although this percentage may seem small, the problems these beneficiaries—and their younger counterparts—face can be personally distressing and are often featured in local and national media reports.

As in previous years, we found that patients seeking a new specialist were less likely to report problems than those seeking a new primary care physician. Among those looking for a new specialist, 87 percent of Medicare beneficiaries reported "no problem" finding one in the past year, compared with 82 percent of privately insured individuals. These trends are consistent with the findings in surveys we conducted in previous years (Table 4-1, p. 77). Although when looking for a new physician, Medicare patients have an easier time finding a specialist than a primary care physician, the Commission is aware that access may be more difficult for some specialties than for others. For example, in previous physician focus groups, psychiatry was the most frequently identified specialty for which physicians reported having difficulty finding referrals for their Medicare patients (Medicare Payment Advisory Commission 2010).

Our patient survey reveals that whites were less likely than minorities to report problems finding a new specialist (Table 4-2). Specifically, among Medicare beneficiaries, 89 percent of whites and 78 percent of minorities reported "no problem" finding a specialist. In the privately insured population, a similar disparity existed: 83 percent of whites and 73 percent of minorities reported "no problem." Several other studies have found a disparity in access to specialists. One study, for example, found that primary care physicians with relatively large proportions of African American patients in their Medicare caseloads reported facing greater difficulty obtaining high-quality referrals to subspecialists (Bach et al. 2004). Though not limited to Medicare patients, a more recent study similarly found that physicians with a larger share of minorities in their practice were more likely to report difficulties obtaining referrals to specialists for their patients (Reschovsky and O'Malley 2008). In this study, physicians attributed such problems to the fact that many of their patients were uninsured or had insurance coverage that posed access barriers rather than to an inadequate supply of qualified specialists in the area.

Although sample size constraints in the Commission's patient survey make statistically significant comparisons among the minority groups difficult, we found somewhat larger disparities between Hispanics and other minorities (Native Americans, Alaskan Natives, Asian Americans, and Hawaiian and Pacific Islanders) than between African Americans and whites in both the Medicare and the privately insured population (data not shown).

Reports of not getting needed physician care were more frequent for privately insured and lower income individuals

Our survey also examines rates of patients reporting that they did not see a physician when they thought they should have. As in previous years, Medicare beneficiaries (8 percent) were less likely than their privately insured counterparts (12 percent) to say that they should have seen a doctor for a medical problem in the past year but did not (Table 4-1, p. 77). This difference was also reported in a 2007 survey conducted by the Center for Studying Health System Change (Cunningham 2008).

In our survey, for both Medicare and privately insured people, those with lower incomes were more likely to report forgoing physician care. Specifically, among those in the lowest income categories, 12 percent of Medicare beneficiaries and 27 percent of privately insured individuals reported forgoing care. In contrast, among those in the highest income category, 5 percent of Medicare beneficiaries and 10 percent of privately insured people reported forgoing care.

The two most frequently reported reasons for forgoing care among both the Medicare and the privately insured samples were that they "just put it off" and "didn't think the problem was serious." Among the 8 percent of beneficiaries who reported forgoing care, less than one-fifth (corresponding to less than 2 percent of the entire beneficiary population) listed physician availability issues (e.g., scheduling an appointment time or finding a doctor) as the problem. As in previous years, privately insured individuals were more likely than Medicare beneficiaries to attribute cost as a factor in forgoing care. Specifically, among the 8 percent of beneficiaries who reported forgoing care, less than one-fifth (again, corresponding to less than 2 percent of the entire beneficiary population) attributed it to thinking that it "would cost too much." In comparison, among the 12 percent of privately insured individuals who reported forgoing care, more than a quarter attributed it to cost.

Rural and urban area analysis

Despite having 8,000 respondents, our survey is not large enough to evaluate access by specific market areas, but we are able to compare access by rural and urban areas. On most indicators, rural and urban Medicare beneficiaries reported generally similar access. Among those looking for a new primary care physician, for example, 83 percent of rural beneficiaries and 78 percent of urban beneficiaries report "no problem." Rural beneficiaries were a little more likely to report having any difficulty scheduling a timely routine care appointment. Specifically, 72 percent of rural beneficiaries and 76 percent of urban beneficiaries reported that they "never" had a problem getting routine care appointments. Our survey also found that rural Medicare patients reported the same or better access than rural privately insured patients. Likewise, urban Medicare patients reported the same or better access than urban privately insured patients. (For more details, see online Appendix A to this chapter, available at http://www.medpac.gov.)

In 2010, we also visited health systems, physicians' offices, and health clinics in Alabama, Kansas, and Montana to gain further insight into access issues in different areas of the country. Specifically, we interviewed physicians, other health professionals, and health administrators in rural areas and conducted focus groups with Medicare beneficiaries in rural and urban areas of each of the three states. These encounters were not meant to be representative of rural and urban areas nationwide, but they provided us the opportunity to probe into access issues related to their community in a more in-depth manner to complement the information collected from our national telephone surveys.

In urban areas, nearly everyone in the focus groups reported that they had a regular doctor and could get appointments reasonably quickly, especially for an urgent problem. In a few instances, participants reported that they or someone they knew had experienced a situation in which a physician was not taking Medicare.

In rural areas, beneficiaries almost universally reported that they have a usual source of primary care, and many said that they could get appointments within a few days. However, beneficiaries stated that they were aware of the limited availability of physicians in their local communities. Beneficiaries reported that access to specialists often involves making appointments for days when specialists are in the local clinic or hospital or traveling to the nearest city or rural referral center. Rural beneficiaries often cited travel and transportation issues as a problem in accessing care.

Physicians in rural areas stated that their practices accepted Medicare patients in addition to patients with other insurance and often the uninsured. They reported that the greatest issue affecting patient access is recruiting physicians to practice in their area. Some of the challenges to physician recruitment in rural areas include their higher frequency of being on call, the rural lifestyle, and a shrinking pool of physicians who practice primary care. When asked about income factors, physicians said that income differences between urban and rural primary care physicians were not a concern.

Other national patient surveys show comparable results

Results from other patient surveys (conducted or sponsored by CMS, The Commonwealth Fund, the Center for Studying Health System Change (HSC), and AARP) are analogous to the Commission's survey results on access to physician services. We summarize findings from these studies below.

- The Consumer Assessment of Healthcare Providers and Systems for Medicare FFS—a large CMS-sponsored survey of FFS beneficiaries—found that for 2010, 88 percent of Medicare beneficiaries reported "always" or "usually" being able to schedule timely appointments for routine care. Also, 91 percent of beneficiaries reported that they "always" or "usually"

were able to schedule an appointment with a specialist as soon as they wanted. The share of beneficiaries reporting major problems accessing physicians (i.e., "never" getting timely appointments) was below 3 percent for both routine and specialty care.

- Results from the 2008 Medicare Current Beneficiary Survey—another large CMS survey of beneficiaries—found that 94 percent of noninstitutional FFS beneficiaries have a usual place for seeking medical care. For the vast majority of them, it is a doctor's office or a doctor's clinic. About 4 percent of FFS beneficiaries said that they had trouble getting care, and 9 percent reported that they had a health problem in the past year for which they think they should have seen a doctor, but did not. Regarding the ability to schedule timely physician appointments, 76 percent of FFS beneficiaries reported that they waited 9 or fewer days for their most recent appointment.
- In a 2007 patient survey, the Commonwealth Fund found that, compared with people who have private insurance, Medicare beneficiaries age 65 years or older reported fewer problems obtaining medical care (specifically, seeing a doctor or medical professional), less financial hardship due to medical bills, and higher overall satisfaction with their health care (Davis et al. 2009). This survey found that access problems were more frequently reported by disabled beneficiaries, however.
- HSC found in its large 2007 household survey that Medicare beneficiaries were significantly less likely to report delaying or not getting needed medical care than people with employer-sponsored private insurance and nongroup private insurance (Cunningham 2008). Although Medicare beneficiaries fared best, this survey found that access has generally worsened for all insurance types over the past decade.
- AARP's 2007 patient survey found that Medicare respondents were less likely to encounter problems accessing physicians than privately insured people age 50 to 64 years (Keenan 2007). Medicare beneficiaries were also more likely than privately insured individuals to report that they were "extremely satisfied" or "very satisfied."
- Using a variety of methods, the Government Accountability Office also concluded that Medicare beneficiaries have stable access to physician services (Government Accountability Office 2009b). This study found that Medicare beneficiaries experienced few problems accessing physician services during a 2007–2008 study period. Furthermore, the proportion of beneficiaries who received physician services and the number of services per beneficiary served increased nationwide from 2000 to 2008.

Physician surveys show that most physicians accept Medicare patients

We also measure beneficiary access to physicians through information obtained in physician surveys, conducted by various organizations and the National Center for Health Statistics. For the most part, these surveys explore physicians' willingness to accept new patients by various insurance types, finding that most physicians are willing to accept some or all Medicare patients.

The National Ambulatory Medical Care Survey—a national survey of office-based physicians—also shows that over the last several years a large majority of physicians continue to accept new Medicare patients. (This survey does not distinguish physicians who accept all new Medicare patients from those who may accept only some new Medicare patients.) For 2008, among physicians with at least 10 percent of their practice revenue coming from Medicare, 90 percent accepted new Medicare patients (Hing 2010).[4] By specialty, 83 percent of primary care physicians and about 95 percent of physicians in all other specialties accepted new Medicare patients. The rate of primary care physicians accepting new Medicare patients fell from 88 percent in 2007.

In HSC's 2008 physician survey, 74 percent of physicians reported that their practices accepted all or most new Medicare patients (Boukus et al. 2009). About 12 percent reported accepting some new Medicare patients and 14 percent indicated that they did not accept any new Medicare patients.[5] For privately insured patients, 87 percent of physicians reported accepting all or most new privately insured patients; 9 percent said they accepted some new privately insured patients, and 4 percent said they did not accept any. Physicians' acceptance of new Medicaid patients was lower (53 percent) than for Medicare and privately insured patients.

Physicians who classified themselves in surgical or medical specialties were more likely than primary care physicians to accept all new Medicare and privately insured patients. Physicians in rural areas were more likely than those in urban areas to accept new patients of all insurance types. Newer physicians were more likely than

physicians who had been in practice longer to accept new Medicare patients. Additionally, employee physicians and physicians who are part of a group practice were more likely to accept all new Medicare patients. The last finding is consistent with a recent report released by the Medical Group Management Association. It stated that 92 percent of surveyed group medical practices currently accept new Medicare patients; another 6.5 percent limit their Medicare patients to those who are established patients aging into Medicare; and 1 percent of practices do not accept any Medicare patients.

In a smaller 2009 survey funded by the Robert Wood Johnson Foundation, physicians were more likely to say that private insurance had better payments than FFS Medicare, but more than half reported that Medicare was the same or better on three measures: paperwork, ease of obtaining services for patients, and autonomy in decision making (Keyhani and Federman 2009).

A different type of study—restricted to claims-processing analysis—also compares Medicare with private insurers. Conducted by the American Medical Association (AMA), the 2009 National Health Insurer Report Card shows that Medicare performed similar to or better than private insurers on several claims-processing measures, such as indicators for timeliness, transparency, and accuracy of claims processing (American Medical Association 2009). The report card noted that, although Medicare had higher rates of denied claims (4 percent) than several of the private insurers, Medicare does not require preauthorization for services, as do many private insurers.

Retainer-based physicians are an extremely small share of physicians but growing in number

The practice of retainer-based care or "concierge medicine" has gained attention in recent years. In general, it is physician-based care (typically for primary care) in which patients are charged a membership fee in return for enhanced services. This model of care is associated with lower patient caseloads per physician. We contracted with NORC/Georgetown to learn more about this type of practice, including its prevalence and impact on beneficiary access to physician care.

Through a variety of research methods, the researchers found about 750 retainer-based physicians in fall 2009. Although this number represents an extremely small share—less than 1 percent—of the total number of physicians practicing in the United States, it marks an increase from the 146 retainer-based physicians identified by the Government Accountability Office in a 2005 report. It is likely that some additional retainer-based physicians were not identified in our updated study, but discussions with physician organizations corroborated the general finding that fewer than 1,000 physicians practiced retainer-based care in 2009.

From interviews, the researchers found that most retainer-based physicians continued to treat Medicare patients and accept Medicare's payments for covered services. Interviews with local and national patient organizations did not reveal access problems for Medicare beneficiaries attributable to the presence of retainer-based care. However, some representatives reported that making a decision about whether to pay a fee and stay with their physician (who adopted the retainer-based model) was difficult for some beneficiaries. The full report from this study can be found on our website.[6]

Rates of physician participation and services paid on assignment remain high

To supplement our data on the supply of physicians treating Medicare patients and beneficiaries' reported access to physician care, we examine assignment rates (the share of Medicare-allowed charges for which physicians accept assigned fee schedule amounts as payment in full) and physician participation rates (the share of physicians and other health professionals with signed Medicare participation agreements to accept fee-schedule amounts as payment in full). Our analysis of Medicare claims data shows that 99.3 percent of allowed charges for physician services were assigned in 2009 (Figure 4-1); that is, for almost all allowed services that year, physicians agreed to accept the Medicare fee schedule amount as payment in full for the service.[7] The assignment rate has held steady at more than 99 percent since 2000.

The high rate of assigned charges reflects the fact that most physicians and other health professionals who bill Medicare are "participating" physicians and other health professionals. That is, for 2009, 95 percent of physicians, limited license practitioners, and other practitioners who billed Medicare had participation agreements with Medicare. Participating providers agree to accept assignment on all allowed Medicare claims in exchange for a 5 percent higher payment on allowed charges. Participating providers also receive nonmonetary benefits, such as being able to receive payments directly from Medicare (less the beneficiary cost-sharing portion) rather than having to collect the total amount from the

beneficiary. This arrangement is a major convenience for many physicians and other health professionals. Participating providers also have their name and contact information listed on Medicare's website and they have the ability to electronically verify a patient's Medicare eligibility and supplemental insurance status.[8] In contrast, physicians and other health professionals who elect to be "nonparticipating" receive a 5 percent lower payment from Medicare for each service they provide but may charge their Medicare patients rates that are up to 9.25 percent higher. This practice of "balance billing" results in higher cost-sharing liabilities for patients. Balance billing is generally rare but varies by geographic area and specialty.

Volume growth consistent with adequate access but highlights pricing and equity concerns

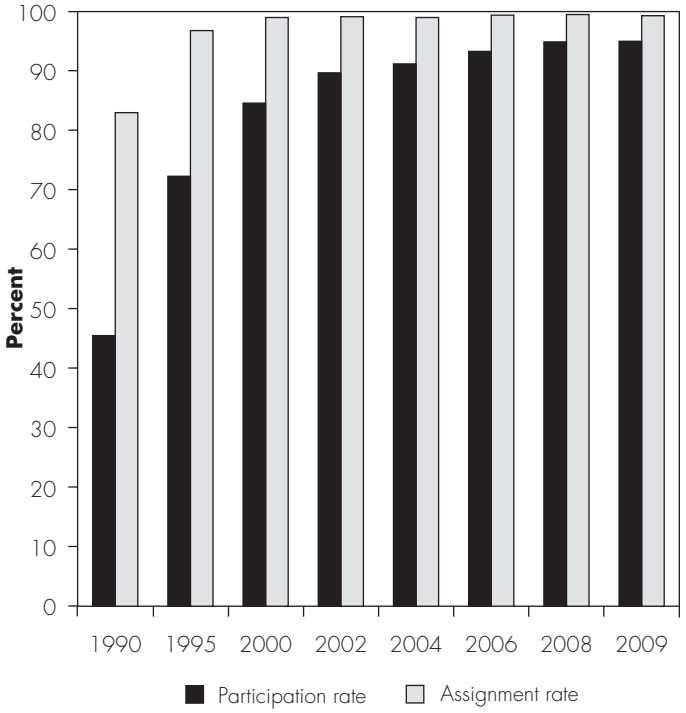
We use annual changes in volume of services as an indicator of beneficiary access—and, by extension, payment adequacy—but caution that interpreting volume growth increases and decreases is complex, sometimes due to factors unrelated to Medicare's pricing of services. Changes in clinical practices, population changes, disease prevalence, legislative and regulatory decisions, shifts in site of care, technology, and beneficiary preferences can sometimes explain a rise or fall in service volume.

In 2009, the volume of physician fee-schedule services used per Medicare beneficiary continued to grow. For this analysis, we used claims data for 2004 through 2009 and calculated per beneficiary growth in the units of service furnished by physicians and other professionals billing under Medicare's physician fee schedule. We weighted the units of service by each service's relative value units (RVUs) from the physician fee schedule. The result is a measure of growth that accounts for changes in both the number of services and the complexity, or intensity, of those services. We thus distinguish growth in volume from growth in units of service: Volume growth includes changes in intensity, whereas unit-of-service growth does not. Compared with analyzing growth in spending, measuring growth in volume removes the effects of price changes.

Across all services, volume per beneficiary grew 3.3 percent in 2009 (Table 4-3, p. 84). For each broad category of service (see text box, p. 85), growth rates varied but were all positive. Services in the "tests" category grew the most: From 2008 to 2009, test services increased 7.4 percent. In comparison, growth rates were 5.5 percent for other procedures, 5.3 percent for major procedures, 2.0 percent for imaging, and 1.7 percent for evaluation and management (E&M) services.

FIGURE 4–1

Medicare participation and assignment rates have grown to high levels, 1990–2009



Note: Participation rate is the percentage of physicians and other health professionals with signed Medicare participation agreements among those in Medicare's Registry. Assignment rate is the percentage of Medicare allowed charges paid on assignment.

Source: Ways and Means Greenbook (2004), CMS Data Compendium (2009), MedPAC analysis of Medicare claims for a 5 percent random sample of Medicare beneficiaries.

In contrast to volume growth for the broad service categories, some subcategories of services saw decreases:

- ***Coronary artery bypass grafts.*** The volume decrease continued a trend in recent years and likely represents substitution of less invasive services for this procedure.
- ***Cardiovascular stress tests.*** The volume decrease was likely related to the decrease in nuclear medicine studies: About 75 percent of nuclear medicine studies include a stress test. The nuclear medicine decrease was small (3.5 percent) compared with cumulative increases of 12.1 percent that occurred from 2004 to 2008.

TABLE 4–3

Use of physician services per fee-for-service beneficiary continues to increase

Type of service	Change in units of service per beneficiary: Average annual 2004–2008	Change in units of service per beneficiary: 2008–2009	Change in volume per beneficiary: Average annual 2004–2008	Change in volume per beneficiary: 2008–2009	Percent of total volume
All services	**3.2%**	**2.7%**	**4.1%**	**3.3%**	**100.0%**
Evaluation and management	**1.7**	**1.1**	**3.3**	**1.7**	**42.2**
Office visit—established patient	1.7	2.0	3.0	2.7	18.3
Hospital visit—subsequent	1.6	–1.8	2.8	–1.0	8.2
Consultation	–0.5	0.2	1.8	0.2	5.4
Emergency room visit	1.7	1.3	3.9	3.1	2.9
Nursing home visit	3.1	3.8	10.8	4.3	2.3
Hospital visit—initial	1.0	–0.3	1.3	–0.2	1.9
Office visit—new patient	1.9	2.6	2.1	2.7	1.7
Imaging	**3.8**	**1.4**	**6.3**	**2.0**	**15.2**
Advanced—CT: other	8.6	3.8	9.8	2.4	2.4
Advanced—MRI: other	6.1	1.2	6.1	–0.1	1.7
Standard—nuclear medicine	1.3	–3.7	2.9	–3.5	1.7
Echography—heart	4.9	2.0	5.4	2.2	1.6
Standard—musculoskeletal	2.7	1.2	2.5	0.6	0.9
Echography—other	8.5	6.9	9.1	10.7	1.0
Advanced—MRI: brain	3.6	–0.5	1.9	–3.0	0.8
Imaging/procedure—other	9.7	7.8	12.6	13.9	0.8
Standard—breast	7.1	4.7	5.0	4.8	0.7
Echography—carotid arteries	4.0	0.5	6.5	1.9	0.6
Advanced—CT: head	6.3	3.7	7.3	2.7	0.6
Advanced—PET	N/A	5.5	N/A	3.3	0.5
Standard—chest	1.4	–1.8	0.9	–2.4	0.5
Major procedures	**1.6**	**3.1**	**2.5**	**5.3**	**8.8**
Cardiovascular—other	–1.2	0.3	0.7	5.9	1.9
Orthopedic—other	6.3	8.1	6.9	11.4	1.3
Knee replacement	4.1	2.8	5.1	3.7	0.7
Explore, decompress, or excise disc	4.1	6.3	4.8	11.1	0.4
Coronary artery bypass graft	–7.7	–5.8	–7.8	–5.8	0.4
Coronary angioplasty	–2.1	–1.0	–2.5	–1.1	0.4
Hip replacement	1.4	4.4	2.5	5.2	0.4
Hip fracture repair	–0.1	–2.4	0.4	–2.0	0.3
Pacemaker insertion	4.8	4.1	2.4	4.7	0.3
Other procedures	**6.4**	**5.9**	**4.9**	**5.5**	**21.8**
Skin—minor and ambulatory	3.6	2.3	4.6	6.7	3.9
Outpatient rehabilitation	6.7	10.9	7.5	11.2	3.0
Radiation therapy	3.0	0.6	7.1	1.9	2.3
Minor—other	15.8	4.6	5.9	4.6	2.2
Cataract removal/lens insertion	0.9	1.6	1.3	2.3	1.5
Minor—musculoskeletal	6.7	4.4	7.8	8.2	1.4
Eye—other	12.9	11.0	7.2	9.4	1.0
Colonoscopy	1.1	–5.0	1.1	–3.4	0.9
Upper gastrointestinal endoscopy	2.1	1.9	2.4	5.3	0.6
Cystoscopy	1.9	0.3	3.8	1.2	0.5
Tests	**1.1**	**2.9**	**4.9**	**7.4**	**5.1**
Other tests	–1.4	6.9	5.8	7.8	2.0
Electrocardiograms	1.6	1.4	1.7	2.1	0.5
Cardiovascular stress tests	0.5	–7.4	0.8	–4.0	0.4

Note: CT (computed tomography), PET (positron emission tomography), N/A (not available). Volume is measured as units of service multiplied by each service's relative weight (relative value unit) from the physician fee schedule. To put service use in each year on a common scale, we used the relative weights for 2009. For billing codes not used in 2009, we imputed relative weights based on the average change in weights for each type of service. Some low-volume categories are not shown but are included in the summary calculations. PET not reported for 2004–2008 because of limits on coverage before 2005.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

Improving the classification of services covered by Medicare's physician fee schedule

Analysis of services covered by Medicare's physician fee schedule optimally requires a service classification system. Without such a system, the services are too numerous—about 7,000 discrete services are billable under Medicare's physician fee schedule—for analysis of trends and other work.

The Berenson-Eggers Type of Service (BETOS) system is the system most commonly used to classify physician services. It was developed with data from the late 1980s for analysis of growth in physician expenditures (Berenson and Holahan 1992). It was later modified at CMS to account for new billing codes and to refine service categories. Since then, CMS has maintained BETOS, every year assigning new codes to categories and deleting codes no longer in use.

The concern now is that parts of BETOS are out of date. Under a contract with the Commission, the Urban Institute convened a group of experts familiar with physician payment and BETOS. Considering the group's discussion, the contractor concluded that the major service categories derived from the system—evaluation and management (E&M), imaging, major procedures, other procedures, and tests—include some errors in service assignment but that those errors are relatively small and not important for purposes of analysis. However, if BETOS is used for payment, errors in service assignment can become unacceptable. The contractor also considered the assignment of services to subcategories, such as office visits by an established patient in the E&M category and knee replacement in the major procedures category. The contractor concluded that CMS should review and restructure the subcategories. The concern was that in many cases the classifications have their origins in medical care as it was provided in the 1980s and that some subcategories are no longer current. For instance, positron emission tomography services are now assigned to various BETOS categories, depending on the service, but could perhaps be more appropriately assembled into one category dedicated to this relatively new technology.

Another issue the contractor considered was whether CMS should revisit the definition of major procedures. For example, BETOS does not differentiate major eye procedures from other eye procedures. Similarly, BETOS does not differentiate major endoscopic from other endoscopic procedures even though some, such as laparoscopic cholecystectomy, are arguably major procedures. While no consensus was reached on how to consistently define major procedures, criteria for making the decision were considered. One option discussed was to define major procedures as those that have a global surgical period of 10 days or 90 days.[10] A second option was to define major procedures as those that meet a threshold for the number of work relative value units assigned.

Given concerns raised about BETOS, we urge CMS to revisit the structure of the system. Further, we are aware that a restructuring of BETOS could require a commitment of resources that is substantial at a time when the agency is meeting many other demands. ■

- ***Colonoscopy, standard chest imaging, and hip fracture repair.*** The volume decrease in colonoscopies is more difficult to interpret because beneficiaries use different types of services for screening, diagnosing, and treating diseases of the colon.[9] We will monitor these services and those for standard chest imaging and hip fracture repair for signs of further changes in utilization.
- ***MRI of the brain.*** The decrease in volume per beneficiary was larger than the decrease in the number of services per beneficiary. The reason for the difference is that the intensity of these services declined—that is, average RVUs per service fell—more than the decline in the number of services. Intensity declined because of shifts from studies done with contrast material to studies done without contrast material.
- ***Coronary angioplasty.*** Volume decreases followed publication of studies showing no better outcomes for patients receiving percutaneous coronary intervention—services included in the coronary

TABLE 4–4

Most ambulatory care quality indicators improved or were stable from 2007 to 2009

	Number of indicators			
Indicators	**Improved**	**Stable**	**Worsened**	**Total**
All	19	16	3	38
Anemia	2	2	0	4
CAD	2	2	0	4
Cancer	2	4	1	7
CHF	5	3	0	8
COPD	1	0	1	2
Depression	0	1	0	1
Diabetes	6	1	0	7
Hypertension	0	0	1	1
Stroke	1	3	0	4

Note: CAD (coronary artery disease), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of Medicare Ambulatory Care Indicators for the Elderly (MACIEs) using the Medicare 5 percent Standard Analytic Files for 2006–2007 and 2008–2009.

angioplasty service category—compared with medical therapy (Boden et al. 2007, Hochman et al. 2006).

- ***Hospital visits.*** Decreases in both initial and subsequent visits are not surprising given decreases in hospital discharges (see Chapter 3).

Other subcategories saw increases in volume per beneficiary, with some of the increases raising questions about necessity:

- ***Imaging services in the "advanced—computed tomography (CT): other" category.*** These services grew at an average annual rate of 9.8 percent from 2004 to 2008 and by another 2.4 percent from 2008 to 2009.[11] This growth has accompanied dramatic increases in CT availability, raising questions about the costs and benefits of the expansion (Baker et al. 2008).
- ***Outpatient rehabilitation, under other procedures.*** From 2004 to 2008, the volume of these services per beneficiary grew an average of 7.5 percent per year. From 2008 to 2009, growth was higher still: 11.2 percent. Because of concerns about growth in spending for these services, limits—known as "therapy caps"—were established as part of the Balanced Budget Act of 1997.[12]
- ***Spine surgery, under major procedures.*** Much of the growth in "orthopedic—other" is attributable to spine surgery. From 2004 to 2008, service volume went up by an average of 6.9 percent and from 2008 to 2009 it rose by 11.4 percent. The "explore, decompress, or excise disc" category also consists of spine procedures. In this category, service volume grew from 2004 to 2008 by an average of 4.8 percent and from 2008 to 2009, by 11.1 percent. Spine surgery is a type of procedure that has prompted questions about effectiveness and financial relationships between surgeons and device manufacturers (Abelson 2008).

Quality of care: Most quality measures for ambulatory care remained stable or improved

Our analysis of Medicare claims data shows that ambulatory care quality, measured by 38 quality indicators, improved or was stable over the most recent period for which national Medicare claims data are available—from 2007 to 2009. Using a set of quality indicators developed by the Commission, called the Medicare Ambulatory Care Indicators for the Elderly (MACIEs), we measured changes over time in the provision of clinically indicated acute care and follow-up care to FFS Medicare beneficiaries who have been diagnosed with certain acute or chronic diseases that are prevalent in the Medicare elderly population (beneficiaries age 65 years or older). We also examined rates of six types of potentially avoidable hospitalizations for five chronic conditions. Online Appendix B to this chapter describes the Commission's development of the MACIEs, and online Appendix C to this chapter lists the 38 MACIEs we used in this analysis (available at http://www.medpac.gov).

Thirty-five of 38 quality indicators improved or were stable from 2007 to 2009

Applying the 38 MACIE measures, we found that, between 2007 and 2009, most of the rates of provision of clinically appropriate care and potentially preventable hospitalizations improved or remained stable (Table 4-4). Among the 38 MACIE measures, 19 showed statistically significant improvement and 16 showed no statistically significant change. This finding indicates that for most measures, rates of beneficiaries with selected conditions receiving clinically indicated services and averting

potentially avoidable hospitalizations were the same or better in 2009 compared with 2007. Additionally, for diabetes and congestive heart failure patients, reductions in potentially avoidable hospitalizations were correlated with improvements in process measures for their conditions.

Our analysis found a decline in 3 of the 38 quality indicators. About a 2 percentage point decrease occurred in the rate of colonoscopies performed as a follow-up diagnostic procedure for beneficiaries with a first-time diagnosis of iron-deficiency anemia, which is a potential symptom of colon cancer. Changes in the rate for this measure should be viewed cautiously, however, as its calculation involves a small percentage of the Medicare population (about 2.2 percent) and thus the indicator is sensitive to very small changes in the number of beneficiaries with claims for follow-up colonoscopy services. Of more concern is that the percentage of beneficiaries diagnosed with iron-deficiency anemia for whom a follow-up colonoscopy is indicated has remained below 30 percent since we first started examining this indicator for the 2002 to 2003 period. The other two indicators in this year's analysis that had small but statistically significant declines were the rates of potentially preventable hospitalizations for beneficiaries diagnosed with chronic obstructive pulmonary disease and for beneficiaries diagnosed with hypertension. Both conditions often can be controlled in an outpatient setting, so a rise in the hospitalization rate for beneficiaries diagnosed with these conditions may reflect a decline in the quality of outpatient care (Agency for Healthcare Research and Quality 2007).

Most measures of potentially avoidable hospitalizations improved or were stable from 2007 to 2009

Six MACIEs measure the occurrence of potentially avoidable hospitalizations and emergency department visits for five selected chronic conditions. Three of these measures improved, one remained stable, and two worsened, as discussed above. The improved measures were the percentage of beneficiaries with diabetes who were admitted to a hospital for serious short-term, diabetes-related complications; the percentage of these beneficiaries admitted for long-term, diabetes-related complications (e.g., lower extremity amputation); and the percentage of beneficiaries with congestive heart failure who had hospitalizations related to that disease. Rates were stable between 2007 and 2009 for the percentage of beneficiaries diagnosed with unstable angina who had multiple emergency department visits during the year.

Notably, the potentially avoidable hospitalization rates (i.e., improvements on the indicators) declined concurrently with increases in the use of other clinically indicated services for the same condition. For example, rates of hospitalization decreased for both short-term and long-term complications of diabetes at the same time that increases occurred in the use of diagnostic testing (such as eye exams and lipid and hemoglobin A1c testing) and periodic follow-up clinical assessments for beneficiaries diagnosed with diabetes.

Medicare payments and providers' costs

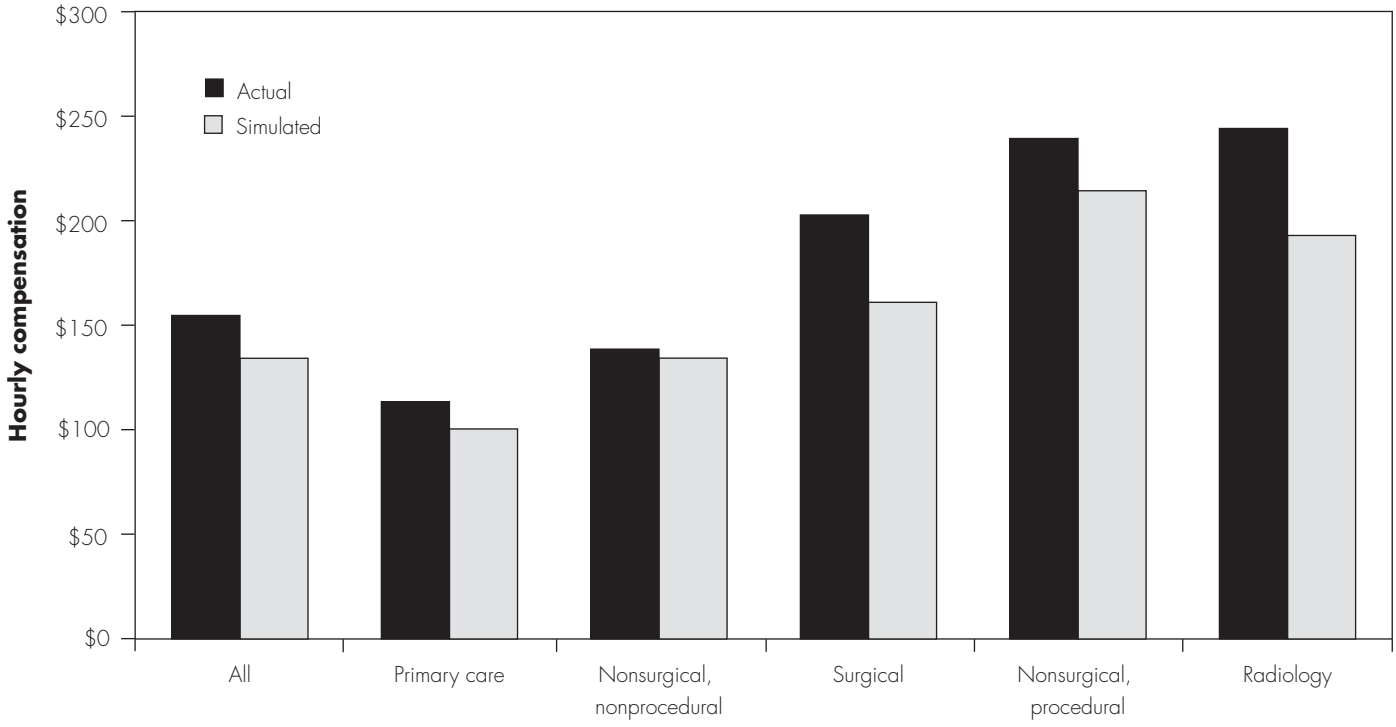
In the absence of cost reports for physician and other health professional services, we use certain indirect measures of this sector's financial status. One such measure is the ratio of Medicare's payments for physician and other health professional services to the payments of private insurers. In 2009, this ratio remained stable. Physician compensation is another indicator. Compensation was lower for primary care physicians than for some specialists, and the disparity between them is large enough to raise concerns about equity and the future of the physician workforce. We also consider forecasts of medical inflation, as measured by the Medicare Economic Index (MEI). These forecasts are revised quarterly and have ranged from 1.0 percent (most recent) to 0.7 percent. The MEI is one of the elements of the formula used to update Medicare's physician fee schedule.

Ratio of Medicare to private insurer fees has remained stable

One measure of Medicare payment adequacy examines the trend in Medicare's allowed physician and other health professional fees (including patient cost sharing) relative to private insurer allowed fees.[13] In the early to mid-1990s, Medicare payment rates averaged about two-thirds of commercial payment rates for physician and other health professional services, but since 1999 Medicare rates consistently have been near 80 percent of commercial rates. For 2009, we find no change from the results reported for 2008. In each of the two years, Medicare's payments for physician and other health professional services were at 80 percent of commercial rates for preferred provider organizations (PPOs) when averaged across all physician services and geographic areas. We base this analysis on a data set of paid claims for PPO members of a large national private insurer.

FIGURE 4–2

Disparities in physician compensation are widest when primary care is compared with nonsurgical proceduralists and radiologists, 2007



Note: Simulated compensation is compensation as if all services were paid under the Medicare physician fee schedule.

Source: Berenson et al. 2010.

More than half of commercially insured individuals are in PPO arrangements, and to the extent that high-deductible plans are PPO based, the PPO segment of the commercial market covers up to 71 percent of enrollment (Kaiser Family Foundation and Health Research & Educational Trust 2010).[14]

Findings on access to care for Medicare beneficiaries relative to the commercially insured population suggest that Medicare's lower average payment rates may have less effect on access than local market factors. HSC research cited earlier found that beneficiaries in markets with the widest gaps between Medicare and commercial payment rates reported access problems in proportions similar to those in markets with narrow payment rate differences (Trude and Ginsburg 2005). Moreover, in markets with higher commercial payment rates relative to Medicare, the commercially insured population did not appear to gain better access than Medicare beneficiaries. These findings suggest that developments in local health systems and markets may strongly influence access for both Medicare beneficiaries and the privately insured.

Compensation is lower for primary care physicians than for specialists

Physician compensation is another measure of payment adequacy. Private payers often use a conversion factor—or multiple conversion factors, depending on the type of service—that differs from Medicare's. The Commission contracted with the Urban Institute, working in collaboration with the Medical Group Management Association (MGMA), for an analysis of the compensation received by physicians—the largest subset of practitioners (Berenson et al. 2010). The contractor used data from MGMA's 2007 Physician Compensation and Production Survey.[15] The contractor compared physician compensation by specialty and analyzed two measures of compensation: "actual compensation," or actual revenues received by a physician, and "simulated compensation," or payments a physician would receive if all the services the

physician furnished were paid under Medicare's physician fee schedule.[16]

Averaged across all specialties, actual physician compensation was about $273,000 per year. Simulated annual compensation for all specialties was about $240,000—12 percent lower.[17] However, broad ranges underlie these averages.

To examine compensation by specialty, we made comparisons using hourly compensation, which enable us to account for differences among specialties in hours worked per week.[18] The specialty groups with the highest hourly compensation rates were the nonsurgical, procedural group and the radiology group (Figure 4-2).[19] Their actual compensation rates were about $244 and $239 per hour, respectively. These rates were more than double the rate for primary care at $114 per hour.[20]

Use of simulated hourly compensation instead of actual hourly compensation resulted in minimal narrowing of the disparities between primary care physicians and specialists. Simulated, radiologists' average hourly compensation was about $193, or 1.9 times the rate of $101 per hour for primary care physicians. For nonsurgical, procedural physicians, the average simulated compensation per hour was about $214, or 2.1 times the rate for primary care physicians (the same multiple calculated with actual compensation rates).

The data on physician compensation raise two issues. One is whether compensation levels are equitable, especially the compensation received by some specialists. The other relates to the future of the practitioner workforce and whether compensation plays a role in the specialty choices of new practitioners.

Equity The level of revenues physicians bring in is a function of price and quantity—the fees paid for services and the number of services furnished. Under Medicare's physician fee schedule, fees are tightly controlled. The fee schedule's RVUs are determined according to statutory requirements. Any change in them must be budget neutral. The fee schedule's conversion factor changes according to a statutory formula: the SGR. Such a payment system can lead to compensation levels that are skewed in favor of some physicians at the expense of others.

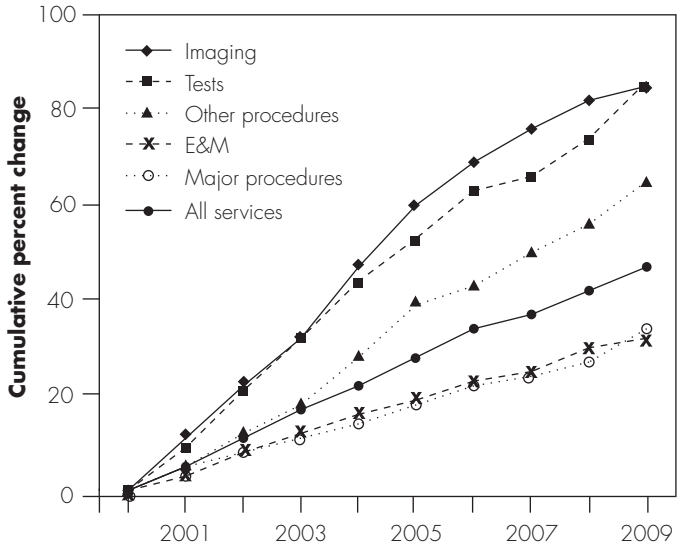
Mispricing is one risk. In previous work, the Commission made recommendations on improving the process through which CMS reviews the fee schedule's relative values for accuracy (Medicare Payment Advisory Commission 2006). Since then, CMS and the AMA Specialty Society Relative Value Scale Update Committee have improved the review process and revalued some services. These activities may have had an effect on some of the disparities in compensation between primary care and other specialties. However, it is likely that mispricing of services in the fee schedule remains a problem. Contract research for CMS and the Department of Health and Human Services Assistant Secretary for Planning and Evaluation has shown that at least some of the fee schedule's time estimates are likely too high (Cromwell et al. 2010, Cromwell et al. 2007, McCall et al. 2006). The question now is whether the problem is limited to a subset of services or whether it is more widespread and whether levels of payment—one service compared with another—are affected. The accuracy of fees can also depend on the circumstances in which a service is furnished. For instance, the Government Accountability Office has found that the fee schedule does not adequately account for efficiencies that occur when a physician furnishes multiple services for the same patient on the same day (Government Accountability Office 2009a). The concern is that mispricing has contributed to inequities in physician compensation.

The ability—or inability—of some practitioners to generate volume poses another risk to the equitable distribution of payments. For instance, primary care practitioners who focus on E&M services have limited opportunity to increase the number of services they furnish. The main component of E&M services is face-to-face time spent with patients, making it more difficult to fit more visits into a day's schedule. By contrast, imaging, tests, and procedures other than major surgical procedures have all grown at much faster rates than other services (Figure 4-3, p. 90). The specialists who furnish these high-growth services are generally the ones at the high end of the compensation scale. This finding is not surprising under an FFS payment system that rewards practitioners for generating volume, regardless of clinical value.

Future of the practitioner workforce The Commission remains concerned that the specialty mix of physicians and other health professionals coming through the graduate medical education pipeline is not well matched to the needs of an efficient, high-quality, high-value delivery system. As discussed in our June 2009 report, a reformed delivery system that focuses on effective chronic care and preventing avoidable hospitalizations will require primary care providers who can function with other health care professionals and specialists as part of a patient's health care team (Medicare Payment Advisory Commission

FIGURE 4–3

Volume of physician services per beneficiary has grown, 2000–2009



Note: E&M (evaluation and management).

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

Certain physicians and other health professionals are eligible for payment bonuses from Medicare

Across most sectors, we consider provider payments in our analysis of payment adequacy. Earlier in this chapter, we discussed the payment cuts scheduled for 2012 under the SGR. Aside from these cuts, PPACA and previous legislation have established bonus payments available to certain physicians and other health professionals. They are listed below:

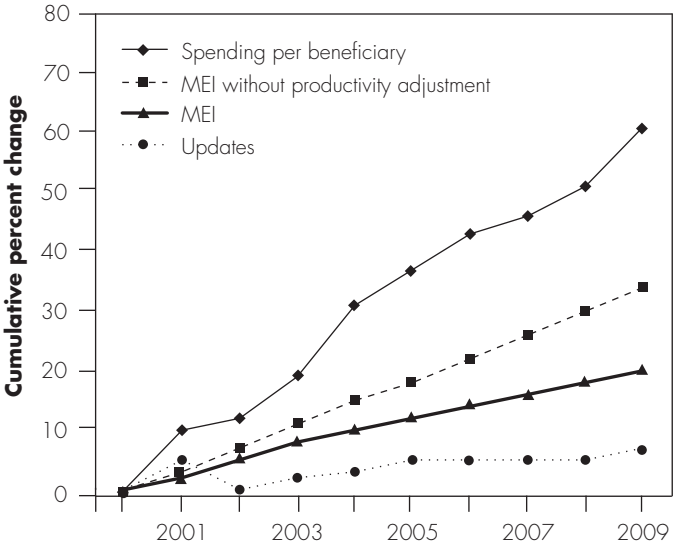
- Since 1991, physicians and other health professionals who practice in designated health professional shortage areas (HPSAs) automatically receive a 10 percent bonus (relative to the fee schedule amount) on all Medicare services they provide.[21]
- Starting in 2011 and ending in 2016, primary care practitioners will receive a 10 percent increase in payments for selected Medicare services, as will general surgeons practicing in HPSAs. For primary care practitioners, the increase complements other, recent budget-neutral policy changes implemented through regulation (see text box).

2009). These primary care providers are essential to a well-functioning delivery system, yet the mix of specialists and primary care graduates from residency programs has been tilting more toward specialists (American College of Physicians 2006, Colwill et al. 2008). Specific to the issue of practitioner compensation, a change in the distribution of compensation across specialties could improve the mix of practitioners. Some research has shown that compensation is an important predictor of medical student specialty choice (Bodenheimer et al. 2007, Leigh et al. 2010). We note, however, that compensation is not the only factor influencing specialty choice and that other factors—such as the ability to master an area of clinical practice—may be more important factors (Borman et al. 2010).

Although the share of U.S. medical students choosing careers in primary care has fallen dramatically in recent years because a growing share is choosing to subspecialize or become hospitalists after residency, the numbers of nurse practitioners and physician assistants have increased (Bodenheimer 2006, Naylor and Kurtzman 2010). In its recent report, the Institute of Medicine called for an expansion of nurses' scope of practice in primary care to help address our delivery system's need for primary care professionals (Institute of Medicine 2010).

FIGURE 4–4

Because of volume growth, spending has increased faster than input prices and the updates, 2000–2009



Note: MEI (Medicare Economic Index).

Source: 2010 trustees' report, IHS Global Insight historical data through second quarter of 2010, and Office of the Actuary 2010.

Recent regulatory increases in payments for primary care under the physician fee schedule

- For 2007, CMS's five-year review—a review of the fee schedule's relative values for physician work—resulted in payment increases for most primary care services.
- Also for 2007, CMS changed its method for determining the relative value of a fee's practice expense component and started a four-year transition to the new values. This methodologic refinement—intended to improve payment accuracy—resulted in increased practice expense values for some types of services, including primary care.
- Starting in 2010, CMS no longer recognizes the billing codes for consultation services. To make the change budget neutral, the agency has allocated the work relative values for consultations to some primary care services—office visits and initial nursing facility visits—and to initial hospital visits.
- Also for 2010, CMS started a four-year transition to practice expense relative values that incorporate data from the Physician Practice Information Survey. During the transition, practice expense relative values are decreasing for some services and increasing for others, including primary care.

Comparing 2006—the year before any of these changes in fee schedule relative values—and 2011, payment rates for primary care services have gone up by 22.5 percent. Of that total, payment updates that apply to all services account for 2.9 percentage points. The remaining 19.6 percentage points are due to changes in relative values. ■

- Under the Physician Quality Reporting System (PQRS), physicians and other health professionals may qualify for a 1 percent bonus on all Medicare services they provide in 2011 and a 0.5 percent bonus in 2012 through 2014. Starting in 2015, those who do not satisfactorily report PQRS measures will be subject to a financial penalty starting at 1.5 percent of their Medicare services.
- The electronic health record (EHR) incentive program provides payments to physicians when they adopt EHRs and demonstrate their use in specified ways to improve quality, safety, and effectiveness of care. Physicians may receive up to $44,000 over five years, starting with $18,000 in 2011. EHR bonuses for physicians in HPSAs are 10 percent higher. Starting in 2015, eligible physicians who do not satisfy the EHR criteria will be subject to a financial penalty starting at 1 percent of their Medicare services.
- Prescribing physicians and health professionals who do not participate in the EHR incentive program are eligible for an electronic prescribing (eRx) bonus of 1 percent on all their Medicare services if they use a qualified eRx system. This program began in 2009. Starting in 2012, eligible professionals who have not yet satisfied the eRx criteria will be subject to a financial penalty starting at 1 percent of their Medicare services.

Input costs for physician and other health professional practices are expected to increase in 2012

CMS's 2012 forecast of the MEI—a measure of changes in the market basket of input prices for physician and other health professional services, adjusted for productivity growth in the national economy—is revised quarterly and has ranged from 1.0 percent (most recent) to 0.7 percent. For these forecasts, CMS collects pricing data from various data sets and surveys. Additionally, CMS calculates a weighted average of expected input price changes from survey data for 2006 collected by the AMA in 2007 and 2008. These weights were updated recently in CMS's final rule.

Medicare's total payments to physicians and other health professionals have increased faster than both the MEI and updates to the fee schedule's conversion factor (Figure 4-4). During the 10-year period ending in 2009, the updates rose 7 percent cumulatively while the MEI rose 20 percent cumulatively. Factoring out the productivity adjustment in the MEI, we see that input prices rose 34 percent. Note, however, that over the same 10-year period, Medicare spending for physician and other health professional services—per beneficiary—increased by 61 percent. Volume growth accounts for the difference between the fee-schedule updates and spending growth.

Aggregate Medicare revenues to practices from this spending growth are a function of volume growth and fee-schedule updates.

How should Medicare payments change in 2012?

In consideration of the expected input cost growth described above and our analysis of other payment adequacy indicators, the Commission recommends a modest update for physician and other health professional services in 2012. We summarize this analysis and recommendation below.

Update recommendation

Our analysis of the most recently available data finds that, overall, Medicare payments for physician and other health professional services are adequate. Access, supply, quality, and volume measures, as well as indirect measures of financial performance, suggest that most Medicare beneficiaries are able to obtain physician and other health professional services with few or no problems. Certain market areas, however, may be experiencing more access problems due to factors unrelated to Medicare—or even private—payment rates, such as relatively rapid population growth. Although a relatively small share of beneficiaries report major problems finding a primary care physician, these beneficiaries' experiences are troublesome. The issue of access to primary care is a serious concern not only to the beneficiaries who are personally affected but also to the functioning of our health care delivery system. The Commission will continue examining multiple approaches for improving Medicare's payment policies to promote primary care.

In this report, we recommend that the Congress change current law to update the physician fee schedule conversion factor for 2012 by 1.0 percent. In making this update recommendation, the Commission takes into account three factors that summon the need to maintain cost pressures. First, the Commission strongly promotes the principle that Medicare's payment systems should encourage efficiency in the provision of Medicare services. Competitive markets demand continual efficiency improvements from the workers and firms who pay the taxes used to finance Medicare. Maintaining cost pressure is a key to achieving efficiency improvements. A second consideration that calls for constraint is the impact on beneficiaries' out-of-pocket spending liability. Updates for physician services carry with them increases to beneficiaries' cost-sharing and premium amounts. Third, the Medicare program faces fiscal sustainability problems, which require committed efforts to resolve if Medicare spending growth is to be slowed.

RECOMMENDATION 4

The Congress should update payments for physician fee schedule services in 2012 by 1 percent.

RATIONALE 4

Our analysis of the most recently available data finds that, overall, Medicare payments for physician and other health professional services are adequate. Access, supply, quality, and volume measures suggest that most Medicare beneficiaries are able to obtain physician services with few or no problems. In our 2010 patient survey, Medicare beneficiaries (age 65 or older) were more likely to report better access to physicians than privately insured individuals (age 50 to 64).

IMPLICATIONS 4

Spending

- Relative to current law, this recommendation is estimated to increase federal program spending by more than $2 billion in the first year and by more than $10 billion over five years. Enactment of any positive update for 2012 would substantially increase Medicare spending relative to current law, because current law under the SGR system calls for negative updates in 2012 and 2013.

Beneficiary and provider

- Relative to current law, the update recommendation would increase Part B premiums and coinsurance liability amounts. Payment increases for physician and other health professional services would maintain both provider willingness to serve Medicare patients and beneficiary access to their services.

Future work

Two areas of future analysis for the Commission include enhancing beneficiaries' access to high-quality primary care and SGR payment policies.

While our analysis of payment adequacy finds that access to physician and other health professional services is good on a national level, a small share of beneficiaries

Summary of health workforce and primary care provisions in the Patient Protection and Affordable Care Act of 2010

- Establishes a National Health Care Workforce Commission, which would report and make recommendations to the Congress and the Administration on the current state and projected needs of the U.S. health care workforce (Section 5101).
- Creates a competitive grant program for states to develop workforce planning strategies (Section 5102).
- Charges Health Resources and Services Administration's National Center for Health Care Workforce Analysis with data collection, analysis, and reporting on workforce programs and establishes state and regional centers for health workforce analysis (Section 5103).
- Reauthorizes and increases funding for several Public Health Service Act programs including Title VII and Title VIII, makes available increased funding for the National Health Service Corps, and establishes scholarship and loan repayment programs for a range of health care and public health professionals (Sections 5201 to 5207, and Sections 5308 to 5313).
- Establishes a primary care extension program through the Agency for Healthcare Research and Quality to educate primary care providers about preventive medicine, health promotion, chronic disease management, mental health service, and evidence-based therapies (Section 5405).
- Authorizes grants to geriatric education centers to support training for clinical faculty and family caregivers in geriatrics, chronic care management, and long-term care (Section 5305).
- Authorizes development grants and payments to support teaching health centers as community-based, ambulatory patient care centers eligible for sponsoring physician residency programs in primary care (Section 5508).
- Directs the Secretary to redistribute 65 percent of currently unused residency slots and directs 75 percent of those slots for training primary care and general surgery and to states with the lowest resident physician-to-patient ratios, to states with the highest ratio of the population living in a health professional shortage area relative to the general population, and to states with rural hospitals (Section 5503).
- Modifies rules governing indirect medical education to promote resident training in ambulatory settings and in didactic and scholarly activities (Sections 5504 and 5505).
- Directs the Secretary to establish a demonstration program for hospitals to increase graduate nurse education training under Medicare (Section 5509).
- Provides a 10 percent payment bonus to qualified primary care practitioners and general surgeons (pertains only to general surgeons in health professional shortage areas) for certain services provided under Medicare; makes Medicaid's payments for primary care services match Medicare's (Section 5501).
- Creates Center for Medicare and Medicaid Innovation to research, develop, test, and expand innovative payment and delivery service models, including the medical home (Section 3021). ■

continue to report major problems finding a primary care physician. The issue of access to primary care physicians is a serious concern not only to the beneficiaries who are personally affected but also to the functioning of our health care delivery system. PPACA contains several provisions to enhance primary care, including increasing Medicare payments for primary care services provided by primary care practitioners (see text box). This policy marks an important step toward ensuring beneficiaries' access to primary care, but more levers should be explored. For example, it may be useful to consider ways to maximize the skills and roles that physicians and health professionals should take in delivering primary care, particularly for the elderly and disabled population. With a growing number of advance practice nurses, the Institute of Medicine recently called for an expansion of nurses'

scope of practice in primary care to address the need for primary care providers (Institute of Medicine 2010). Other payment approaches to explore may include examining ways to reimburse for patient–clinician communication when it avoids the need for office visits.

With respect to the current SGR system, the Commission recognizes the mounting frustration of physicians, other health professionals, and their patients stemming from the uncertainty of future Medicare payments and the size of looming payment cuts. Often referred to as "temporary fixes," legislative SGR overrides have been covering relatively small periods of time. While these stop-gap measures have averted payment cuts, their short-term nature has become problematic for providers and burdens CMS's resources. In addition, some of these overrides have contributed to the amount of dollars that need to be recouped in accordance with the SGR formula.

In future work, the Commission will examine expenditure target policies and the budgetary issues they carry. We will discuss ways the current SGR may be adjusted to achieve desired policy goals, such as equitable compensation among physician specialties, access to primary care, accountability for patient health, and efficient Medicare spending. ■

Endnotes

1 See http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_Physician.pdf.

2 The 2010 survey included an oversample of African Americans, Hispanics, and other minorities—including Native Americans, Alaskan Natives, Asian Americans, and Hawaiian and Pacific Islanders. All respondents had the opportunity to take the survey in English or Spanish.

3 Within that population, our survey results do not distinguish Medicare FFS enrollees from those in Medicare Advantage (MA) plans because of the technical difficulty in obtaining reliable self-identification of FFS or MA enrollment from surveyed individuals. Similarly, we do not distinguish by type of private coverage among the non-Medicare population in our survey.

4 If physicians who were in practices that no longer accepted any new patients (regardless of insurance type) were excluded from this calculation, then the share of physicians accepting new Medicare patients would increase to 96 percent.

5 These percentages include practices with potentially small shares of Medicare patients, such as pediatrics.

6 See http://www.medpac.gov/documents/Oct10_RetainerBasedPhysicians_CONTRACTOR_CB.pdf.

7 In 2009, 97 percent of allowed charges were for services provided by participating physicians, another 2 percent were for services provided by nonparticipating physicians who decided to accept assignment. Only 0.7 percent of allowed charges were for services provided by nonparticipating physicians who did not accept assignment.

8 Participation agreements do not require physicians to accept new Medicare patients.

9 Within the colonoscopy type of service, there are two general categories of services: diagnostic colonoscopy and screening colonoscopy. The volume of services fell in both of these categories. However, within screening colonoscopy, there was a 3.8 percent increase in the volume per beneficiary of screening colonoscopy for high-risk individuals.

10 A procedure with a global surgical period is one for which Medicare pays a bundled fee for preoperative visits, the procedure itself, and postoperative hospital and office visits. The duration of a global surgical period is the typical number of days during which the bundled services are furnished.

11 The 2009 growth rate for these services includes—but is not limited to—rapid growth in CT guidance for radiation therapy.

12 A more detailed description of the therapy caps can be found at: www.medpac.gov/documents/MedPAC_Payment_Basics_10_OPT.pdf.

13 Although allowed amounts include patient cost-sharing liabilities, they do not include balance billing amounts that would exceed the fee-schedule amounts.

14 Our analysis relies on data from one large national insurer to determine a national average of the relationship between Medicare and private PPO payer rates. While we report a national average, the data show that payment rates vary substantially from one geographic area to another, within geographic areas, across providers within a given market, and by the type of service across and within markets.

15 This survey predated increases in payment for primary care and other services discussed later in this chapter. Those increases have included the last three years of the transition to a new method for determining relative values for practice expense, a change in billing for consultation services, and a transition to practice expense relative values that incorporate data from the Physician Practice Information Survey. In addition, payment of a 10 percent bonus for eligible primary care practitioners and general surgeons (general surgeons practicing in health professional shortage areas) started on January 1, 2011.

16 In simple terms, simulated compensation was calculated in two steps. Step 1 was annual total RVUs for the services furnished by a physician multiplied by the Medicare conversion factor. Step 2 was the result of Step 1 multiplied by a ratio that was the physician's actual compensation divided by collections (revenues) from the physician's professional services and collections from other sources attributable to the physician such as laboratory services and injectable drugs. Further details are in the contractor's report.

17 The 12 percent difference between simulated compensation and actual compensation does not mean that Medicare's payments for physician services are 12 percent lower than private payers' payments for those services. The compensation estimates include compensation attributable to physician services and to services other than physician services, such as laboratory services and injectable drugs. In addition, the comparison is simulated Medicare compensation relative to actual compensation that is attributable to private payers' payments but also some Medicare payments.

18 Our contractor noted that estimates of hours worked from the MGMA survey are lower than estimates from other sources such as the Physician Practice Information Survey. However, after comparing data from different surveys on physician hours worked, the contractor found very little systematic variation across specialties. From this finding, the contractor concluded that the MGMA data may produce higher absolute compensation per hour but that the data do not affect analysis of relative hourly compensation across specialties.

19 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, and pulmonary medicine.

20 The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.

21 This bonus started at 5 percent in 1989 and was limited to rural areas. In 1991, the bonus payment was raised to 10 percent and urban HPSAs were included.

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